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Medicine and the Maelstrom

The Debate on American Health Care

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IN MY ROLE AS A SPOKESMAN for the California Medical Association, I spend most of my time speaking to groups of other doctors or to groups of politicians. In either case, I often find the audience biased on the subject of medical care. So you can understand that I welcome this chance to talk to a more diverse audience.

As the Health Problems Committee of the Commonwealth Club is well aware, American health care and medical care have become subjects of national debate in recent years. Looking through recent issues of magazines or newspapers, it would seem that the country has been inundated with experts on health care. And some are insisting that drastic changes are necessary in our system of delivering health care.

It is valuable to examine for a moment why some people are advocating a complete restructuring of our present approach to health and medical care. Perhaps the major argument used is that the level of health care in the United States ranks far below that of a number of other countries, especially some smaller ones in Western Europe. For instance, the following statement appeared not too long ago in a national magazine:

> The state of our nation's health is bad. We rank far below less affluent countries. In infant death rates, the United States stands tenth; in death from diabetes, fourteenth; from heart disease, thirteenth; in overall death, fifth. And in prolonging life, we are eighth.

A similar observation was made about the same time by Senator Jacob Javits in a letter to the *New York Times*. He said:

> Our nation has unchallenged leadership in biomedical research and medical technology. Yet among the nations the United States ranks thirteenth in infant mortality, eleventh in maternal mortality rates and twenty-second in life-span for men.

These are easy, "simple" arguments to present, and they sound convincing to the general public. But they contain a number of fallacies. I draw your attention to the two differing figures used for infant mortality rates in these two quotes, ranking the United States tenth and thirteenth respectively. The fact that they *are* different is significant. In recent reports and articles, the relative position of the United States in regard to infant mortality has varied from sixth to 28th—depending on the person or agency doing the reporting.

The inconsistencies originate from a number of sources. They may spring from the use of different sources for the figures on infant mortality for a given country. And different countries use different ground rules for collecting and listing health statistics.

This leads us to an important question: How do you measure how effectively a health care system meets the needs of the people?

We believe that general health, growth and development, improved life expectancy, eradication of infectious disease, elimination of contagious disease such as poliomyelitis, tuberculosis, typhoid fever and tetanus, advances of medical and surgical techniques for the early detection, treatment and cure of heart disease, stomach ulcers, cancer and other killer diseases, are yardsticks by which good medical care can be measured. By all of these standards, medical care in this country excels.

In recent years, some have attempted to equate levels of infant mortality with the effectiveness of our health care system. This fallacy needs to

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be dispelled. Sweden, with the world's lowest infant mortality, has the world's greatest mortality from stomach ulcers and the second highest from pneumonia. Most studies reveal clearly that excess infant mortality is rooted in poverty, malnutrition and racial discrimination. Infant mortality in fact, correlates best with the level of education achieved by the mother. As we grapple with these social ills, our infant mortality rates have sharply declined.

Deficiencies but Not "Crisis"

This is not to say that our present system is perfect. It contains some very real inadequacies. Some people who need care go without it—because they cannot afford it, because it simply isn't available to them, because they don't know how to obtain it, or because they lack adequate education to use what is available. Catastrophic illness may occur at any income level, creating serious financial problems. Some people living in remote rural areas or urban ghettos have no readily available access to the health care system. In addition, government health programs promise full health care, but seldom budget enough to provide it. For example, California's Medi-Cal program for the poor has not achieved its objectives—despite the fact that this fiscal year California doctors, in effect, are subsidizing Medi-Cal by about $61-million because of substandard reimbursement of fees under the program. But all these factors do not constitute a health care "crisis"—as is sometimes alleged. Rather they represent deficiencies that must be eliminated.

The basic fact that the quality and quantity of medical services in the United States is now at an all-time high, and in the aggregate, favorably compares with the situation in any other nation in the world cannot, and should not, be ignored. Then too, it should be recognized that mortality and morbidity rates in the United States are at the lowest levels ever, and the situation in this respect is continuing to improve. Therefore, it is apparent that our need in this country is not to restructure drastically or further control or destroy our system of medical care—as some critics would have us do. Instead the need is to expand it so that it is within reach of those who do not now receive its benefits and services. In other words, we must fill the gaps in our present system without discarding those aspects in which it traditionally does a good job.

Freedom of Choice

Americans today have the finest system of medical care ever available anywhere in the world. Our goal should be to provide access to this high quality medical care for everyone. We believe that medical care can be delivered best when both patients and physicians have complete freedom of choice . . . when each doctor can assume full responsibility for his own patients, and exercise his knowledge, experience, skills and judgment, free from outside interference. We believe that this freedom of choice for patient and doctor can only be preserved by our voluntary private system.

A former Secretary of Health, Education and Welfare, John Gardner, in commenting about this situation, recognized the necessity and the value of change but added: "This is not to say that we must be infatuated with everything new and reject everything old. In all evolutionary growth there is a complex interweaving of continuity and change. One of the purposes of social change is to find new solutions that will preserve old values. When the spring dries up, the farmer seeks a new source of water, not for the love of novelty but to bring himself back into balance with his environment."

We who are concerned with medical care in this country must find answers to some important questions. How do we go about finding "new solutions that will preserve old values?" What "old values" do we wish to preserve?

Certainly we wish to preserve the traditional stress placed on quality care. Maintaining and improving the present high quality of medical care have long been areas of intense concern for the medical profession. In this day of increasing demand for services and the increased role of third parties, these activities remain a major concern.

As in other areas of the nation, physicians in California have approached the subject of assuring quality care through a system of "peer review." California Medical Association and the county medical societies have standing peer review committees—hundreds of experienced physicians who volunteer their time to review the quality and appropriateness of the medical care other doctors provide for their patients. Among many other aspects, I might mention the work of hospital tissue committees in reviewing indications for surgical operation, the survey teams

that review hospital medical staffs and the committees reviewing medical care in nursing homes.

In addition, the role of peer review has been expanded into the area of cost control—evaluating the medical charges made by a physician. A third and related objective of peer review activities is to promote effective utilization—to discourage unnecessary laboratory tests or excessively long hospitalization. Another important aspect is to deal, on the patient's behalf, with underutilization. This obviously can be more serious for the patient in maintaining high standards for his care.

Continuing Medical Education

Another approach we are taking in California to insure continued high quality care is the California Medical Association's program to certify physicians' continuing medical education. To be certified, physicians must participate in a minimum of 200 hours of continuing medical education in a three-year period. The CMA provides specific mechanisms for accreditation of continuing educational programs and acts to improve educational quality and make it more effective as a means of improving patient care.

It also should be noted that the medical profession is actively seeking ways to eliminate health care deficiencies that do exist, without sacrificing the already high level of medical care we have achieved in this country. Many new and innovative approaches to the delivery and financing of medical care are being studied in California—and throughout the nation.

The California Medical Association feels that the "pilot project" is a particularly useful tool in this regard. This is a method of judging the effectiveness of new approaches through a controlled, small-scale trial project. For example, a San Joaquin pilot program is studying whether the state's Medi-Cal program for the poor can be improved by putting providers' services on a prepaid basis. The project hopes to determine whether a greater percentage of the eligible persons would be seen by a greater proportion of physicians under this approach. If so, then this method would assure quality medical care and—at the same time—perhaps supply it for less cost.

In our efforts to make good medical care available to everyone in the state, we are using a variety of approaches, and I'll cite just a few examples.

Better Distribution of Physicians

CMA maintains a Physician Placement Service created specifically to place physicians in locations where medical services are needed. We all have heard references to a "physician shortage" in this country—but recent information indicates that solving our health manpower problem is more a matter of better distribution than finding new ways to increase the number of physicians. According to the recent President's Manpower Report to Congress, by 1980 there will be about 440,000 physicians in this country—enough to eliminate the alleged doctor shortage. This figure represents a predicted ten-year increase of 120,000 physicians, using present educational approaches. Stated another way, the present proportion of 157 doctors for every 100,000 people will increase to 180 doctors per 100,000 people by 1980. Also in regard to the alleged doctor shortage, it should be noted that the overall number of physicians in this country is increasing at a rate three times that of the general population growth.

Our component county medical societies are active with projects on the local level. Shasta-Trinity County Medical Society has developed a unique emergency care program. The San Francisco Medical Society is working with the Office of Economic Opportunity in bringing medical care programs to the inner city. Kern and Sacramento County Medical Societies are operating clinics to bring medical treatment to rural migratory workers. Monterey County Medical Society is the fiscal agent for a pioneering rural "health care team" approach that covers a wide area around King City. The Los Angeles County Medical Association is doing innovative work in such areas as peer review and extended care surveys. Other county medical societies—in the ways they find best suited to local needs—are seeing that health care is brought to migrant agricultural workers, into rural areas and urban ghettos.

The foundation for medical care is another approach being taken by the medical profession —and one in which California has led the nation. These foundations are non-profit organizations of doctors sponsored by local county medical societies. They are concerned with the development and delivery of medical services at a predictable cost, whether it be privately or publicly financed.

These are a few of the approaches being taken by the medical profession to improve our system of health care.

Nonetheless, as much as the medical profession—or any other single group—is doing to seek solutions, these problems sometimes transcend the resources available to us alone.

All of this leads me to another important consideration. It is necessary that we Americans rethink some of our ideas about improving *health* care. Americans usually fail to consider that there are other factors even more influential than *medical care* in a nation's health. Specifically, environmental factors; inadequate general health education; automobile and home accidents; poor housing, sanitation and nutrition; obesity; alcoholism and drug abuse; cigarette smoking; suicide, homicide and other violent crimes are all factors to which our nation has devoted too little attention. Instead of making concerted efforts to solve these problems, we too often have fallen victim to the idea that new programs of government financing will somehow magically eliminate all health-related difficulties. Obviously, this simply is not so. The present major difficulties being experienced nationally by the Medicare program for the elderly and the Medicaid program for the poor testify to that fact.

The Future for Medical Care

This encapsulates the present situation. But what of the future? What does the future hold for medical care in this country?

Some hospital spokesmen foresee the rise of the hospital as a center of medical care. Stephen Morris, the president of the American Hospital Association, is one of the advocates for changing the role of the hospital. However, there are serious deficiencies in any proposal that promotes the corporate practice of medicine—as embodied in this concept of the hospital as the center of care. To state an obvious fact, the purpose of any system of medical and health care is to bring together one patient who needs medical care and one physician who can see that he receives care. It can never be forgotten that medical care is given to one individual at a time. In the final analysis, only physicians can deliver medical care. And any approach to medical or health care that neglects this fact cannot adequately serve the needs of the patient.

The current debate about national health insurance undoubtedly will play an extremely important role in determining what the future holds for health care in this country. Sixty-two health insurance bills have been introduced in the House of Representatives this session. Another dozen, some similar to House legislation, are in the Senate. However, it seems unlikely that a program of national health insurance will pass in the immediate future. Congressman Wilbur Mills, chairman of the powerful House Ways and Means Committee—the committee through which such proposals must move—has made some interesting observations in this regard. He has said that he believes the period of time necessary to consider national health insurance is not available this year, and therefore his committee probably will not start considering proposals until 1973. Moreover, he has said it is not possible at this time to establish what priority national health insurance would have next year before the committee.

Improving What We Have

Nonetheless—unless there is a change in public and political sentiment—it looks like some increased involvement of government in health care probably will take place within the next few years. Strictly defined, national health insurance is a program for financing almost all health care services for the vast majority of the population of a country through a governmentally-administered insurance system. Of the major pending proposals concerning national health care, only two are strictly national health insurance—the Kennedy Bill and the Javits Bill. Other proposals, such as those of the Nixon Administration, the American Medical Association, and the Health Insurance Association of America, generally would build upon—rather than destroy—the existing health insurance and delivery structures. Such plans recognize that it is much better to utilize and develop a health care system that is now providing reasonably adequate protection to some 80 to 90 percent of the population than to inaugurate a new system of unproved quality and capability. Similarly, proposals for catastrophic insurance alone—such as those of Senator Long and Congressman Hall—would utilize the existing administrative and delivery systems.

"Ameriplan," a proposal developed by a committee of the American Hospital Association, which later withdrew its support, has recently

been submitted by Congressman Ullman of Oregon. It would have a significant effect on the medical care delivery system since it would center such services in "health care corporations" and would thus eliminate solo and small-group practices from the scene.

The administration's proposal for national health insurance—known as the National Health Insurance Standards Act—has as a basic feature the establishment of "Health Maintenance Organizations." In addition, various members of Congress have also proposed their own concepts of what constitutes an HMO. Currently, three major HMO bills are being considered by the Senate Health Subcommittee. The specific nature and scope of the HMO concept in the future, therefore, depends on what legislation in this field Congress decides on.

Exactly what is an HMO? First, it is a form of contract group practice. Based on bills before Congress, an HMO must assume legal responsibility for providing a broad range of health care services, including both professional and institutional services, and accountability for both the quantity and quality of services provided. An HMO would provide emergency care, hospital and physician care, ambulatory physician care and outpatient preventive medical services.

Payment for such services must be on a prospective capitation basis. Individuals or families must pay a monthly fee in advance with the fee ordinarily set for a period of at least a year at a time.

Let us examine the merits of the HMO concept. We feel that it is possible the HMO approach *may* provide one method of solving health problems. However, we note that the administration has already made some 110 grants for planning and feasibility studies for HMOs. The results from these studies are not yet in. They have not yet provided essential data regarding the quality and extent of services that can be provided, their accessibility to beneficiaries, the cost of providing them, and their acceptability to both consumers and providers. We can only conclude that any legislation to implement a concept which is still undergoing testing would be unwise and premature.

Professional Standards Review

The Professional Standards Review Organization—or PSROs—is another legislative concept that could fundamentally affect our present approach to health care. Introduced by Senator Bennett as an amendment to the Social Security bill, the PSRO approach would establish a governmental program of peer review. Stated briefly, non-profit organizations would be established in local areas to decide whether care provided under Medicare and Medicaid is medically necessary and to determine whether it measures up to professional standards.

We feel this approach has serious drawbacks. First, it would bring large-scale federal involvement into a function already successfully being performed by the medical profession. Furthermore, it would bring with it unnecessary and possibly harmful federal government controls. For instance, the amendment delegates almost complete authority over the program to the Secretary of Health, Education and Welfare. HEW would be allowed to set up regional norms and standards for medical care that would be subject to control by a National Professional Review Council and thus subject to the possible imposition of national standards—ignoring differing local circumstances and needs. In addition, PSROs —as proposed—would bypass one of the California Medical Association's most effective activities, the medical staff survey program.

Any one of these proposals we have discussed could have a fundamental effect on the future of medical care in this country.

As we have illustrated here, the medical profession continues to be very active in attempting to find solutions to the deficiencies in America's health care system. We have identified the problems as being concerned with access, quality and cost of care. And we have tackled these problems voluntarily—building on the strengths of the health care system of the private sector that has been responsible for this country's greatness. This voluntary approach is indeed an important aspect of our American system and one of the hallmarks of its success. It is important therefore that organizations concerned with health care remain independent of government control, remain responsive and close to the people. This is our belief and the basis of our activities. We are preparing for the future by dealing with the problems of the present—ever mindful of the fact that our primary obligation remains the best interest of our patients.